

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08360

301

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Maynard Alexander

3. (b) Social Security Number
214-09-7626

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)
 10. Usual occupation.....
 11. Industry or business.....

12. Name.....
 13. Birthplace.....
 14. Maiden name.....
 15. Birthplace.....

16. Informant.....
 Address.....

17. Burial.....
 (Burial, cremation, or removal. Which?).....
 Date thereof.....
 (month) (day) (year)
 Cemetery or crematory.....
 Location.....
 18. Funeral director.....
 Address.....

19. Aug 10 1946 E. Lee McElroy Registrar

MEDICAL CERTIFICATION

5:20 P.M.

20. DATE OF DEATH..... August 6, 1946, at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14, 1946, to August 6, 1946
 and that I last saw him alive on Aug 6 - 1946

Immediate cause of death.....
 Obstruction of Arteries
 Carcinoma

Due to.....

Due to..... Carcinoma

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Carcinoma Arteries

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... P. W. I. ... M. D. or other

Address..... Date signed..... 8/7/46

RECEIVED
AUG 13 1946
BUREAU OF S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *93d*

CERTIFICATE OF DEATH

Reg. Dist. No. *302*

08361

207

1. PLACE OF DEATH:

County *Washington County*
 City or town *Chewsville Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *1 yr. 9 months*
 Hospital, institution, or street address where death occurred:
Chewsville Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Washington*
 City or town *Chewsville Maryland*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *Chewsville Maryland*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

James Eugene Ardinger

3. (b) Social Security Number

None

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*
 6. (b) Name of husband or wife *Ida Catherine Patton Ardinger (deceased)*
 7. Birth date of deceased (mo., day, yr.) *July 20, 1866*
 8. AGE: Years *80* Months *25* Days *25* If less than one day *hrs. min.*

9. Birthplace *Williamsport, Maryland*
 (Town, county, and state)
 10. Usual occupation *Mechanist*
 11. Industry or business *Byrons Tannery*
 12. Name *Charles Ardinger*
 13. Birthplace *Williamsport, Md*
 14. Maiden name *Emma Nitzel*
 15. Birthplace *Williamsport, Maryland*

16. Informant *Mrs. A. E. Sinsel (daughter)*
 Address *Chewsville Maryland*

17. Burial *Burial* Date thereof *Aug. 14 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory *Liverview Cemetery*
Williamsport, Maryland
 Location

18. Funeral director *Edith V. Leaf*
 Address *#7 Church St. Williamsport Md.*

19. *Aug-13* 19 *46* *Margaret B. Bowyer*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 11 1946 5 P* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug. 11 1946* to *Aug. 11 1946*
 and that I last saw him alive on *Aug. 11 1946*

Immediate cause of death *Myocardial infarction*
chronic myocarditis
 Due to *atherosclerosis*
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE *P. J. Prather*
 Address *Hagerstown* Date signed *8.13.46*
 M. D. or other

RECEIVED

AUG 15 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1662

CERTIFICATE OF DEATH

 08362 302
 ★ Reg. Dist. No.

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
169 Summit Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 169 Summit Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Elva Ann Bachtell

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife John Henry Bachtell
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) November 6, 1854
 8. AGE: Years 91 Months 9 Days 13 If less than one day
 hrs. min.

9. Birthplace Smithsburg, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

MOTHER FATHER
 12. Name David Ridenour
 13. Birthplace Smithsburg, Md.
 14. Maiden name Elizabeth Brown
 15. Birthplace Smithsburg, Md.

16. Informant Mrs. Bertha Wolcott
 Address Hagerstown, Maryland

17. Burial Date thereof 8-21-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Stouffer's Grave Yard
 Location Greensburg, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Aug 21 19 46 Elva Ann Bachtell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 19 46 at 8:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 46 to August 19 19 46
 and that I last saw him or her alive on August 18 19 46

Immediate cause of death Arteriosclerotic heart disease

Due to Arteriosclerosis DURATION 4 years

Due to

Other conditions Vascular hypertension 5 years
fracture of left hip - 6/23/45

(Include pregnancy within 8 months of death)

Major findings of operations none

Autopsy results none Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accidental Date of June 23, 1945
 Where did injury occur? Hagerstown Washington Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home
 Means of injury fall on pavement Injured at work? no

23. SIGNATURE RB Bowers M. D. or other MD
 Address Hagerstown Md Date signed 8/20/46

RECEIVED
AUG 23 1946
BUREAU V M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Dr. wells 197

08363

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
Alexander Hotel
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ohio County Cuyahoga
 City or town Cleveland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9308 Miles Ave
 (If rural, give LOCATION)
None ✓
 2. (a) If veteran, name war

3. (a) FULL NAME

James Badalamenti JAMES

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Celia
 6. (c) If alive, give age 47 years
 7. Birth date of deceased (mo., day, yr.) April 2 1893
 8. AGE: Years 53 Months 4 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Carini Prov. Palermo Italy
 (Town, county, and state)
 10. Usual occupation Merchant Retired
 11. Industry or business Fruit
 12. Name Anthony Badalamenti
 13. Birthplace Carini Italy
 14. Maiden name No. Record
 15. Birthplace Non Record

16. Informant Antonio Bertolino
 Address Cleveland Ohio
Removal Date thereof '8/9/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lakeview Cemetery
 Location Cleveland Ohio
Andrew K. Coffman
 18. Funeral director
 Address Hagerstown Md.
Aug. 8. 46 Chas. Bowers
 19. (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 19 46 at 10 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____
 Immediate cause of death _____ DURATION
Acute coronary thrombosis 6hrs
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results as above '8/8/46
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide No Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
DEPUTY MEDICAL EXAM
WASH. CO. MD.
 23. SIGNATURE Robert Wells M. D. or _____
 Address Hagerstown Md. Date signed Aug 8/46

RECEIVED
AUG 10 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08364 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
12 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
923 West Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 923 West Washington Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Kurvin J. C. Bott

3.(b) Social Security Number

219-12-2137

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Emma E. Bott B.(c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) June 19, 1882
 8. AGE: Years 64 Months 1 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace York County, Pa.
 (Town, county, and state)
 10. Usual occupation Retired Trainman
 11. Industry or business
 12. Name John Bott
 13. Birthplace York County, Pa.
 14. Maiden name Mary Fockler
 15. Birthplace York County, Pa.

16. Informant Mrs. Kurvin J.C. Bott
 Address Hagerstown, Maryland
 17. Burial Date thereof 8-16-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland
 19. Aug. 16, 1946 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION EDT

Aug/13/ 19462D. DATE OF DEATH Aug/13/ 1946 19. at 5 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19. to _____ 19. and that I last saw him _____ alive on _____ 19.

Immediate cause of death _____ DURATION _____
Fractured skull(c)
 Due to Fractured (l) shoulder girdle closed
 Due to Fractured (r) tibia & fibula closed

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of Aug/13/46
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury Struck by auto Injured at work?

23. SIGNATURE A. P. [Signature] DEPUTY MEDICAL EXAM.
Hagerstown, Md. WASH. CO., MD.
 M. D. over-signer _____ Date signed 8/14/46

RECEIVED
AUG 19 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

08365

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 12 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 100 North Ave.
(If rural, give LOCATION)

2.(a) if veteran, name war

3. (a) FULL NAME

Mary E. Braungard.

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

August 1878

6. (c) If alive, give age... years

8. AGE:

68

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace... Hagerstown, Md.

(Town, county, and state)

10. Usual occupation

Sales Ladie

11. Industry or business

FATHER

12. Name

Jacob C. Braungard

13. Birthplace

Maryland

MOTHER

14. Maiden name

Elmira Hawbaker

15. Birthplace

Pennsylvania

16. Informant

J.E. Braungard

Address

Hagerstown

17. Burial
(Burial, cremation, or removal. Which?)Date thereof Aug 9, 1946
(month) (day) (year)

Cemetery or place of burial

Rose Hill

Location

Hagerstown

18. Funeral director

Fred W. Kraiss

Address

Hagerstown

19. Aug 9 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH August 7 1946 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 9 1945 to August 7 1946
and that I last saw him alive on August 6 1946

Immediate cause of death

Due to... Uremia
Chronic nephritis

Due to

Other conditions

Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. None Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address... Hagerstown, Md

M. D. or other

Date signed 8/8/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 10 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1602

CERTIFICATE OF DEATH

Reg. Dist. No. 08366 302

1. PLACE OF DEATH:

County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution?

4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County FredrickCity or town Sabillasville MD
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war

no

3. (a) FULL NAME

Carolyn Lee Brown

3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Aug 18 - 1946

8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

9. Birthplace

Washington Co. Hospital Pa
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 21 - 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 August 19 46 at 5:35 P. M.

21. I CERTIFY that death occurred on the day above stated; that I attended deceased from

Aug - 20 19 46 to Aug 20 19 46and that I last saw him alive on Aug - 20 19 46

Immediate cause of death

Infantile Cerebral
Paralysis
Cerebral Hemorrhage

DURATION

all y.

Due to

Due to

Other conditions

(Includes pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

None done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D.

Address 214 N. P.O. St.Date signed Aug - 20 - 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 23 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08367302
Reg. Dist. No.

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Route #2.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Fair View
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Hagerstown County... Washington
 City or town... Hagerstown Route # 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Route # 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Zachariah Carbaugh.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Jan 8, 1872
 6.(c) If alive, give age..... years

8. AGE: Years 74 Months 7 Days 4 If less than one day
hrs.min.

9. Birthplace... Wilsons Washington County Md
 (Town, county, and state)
Retired Plasterer

10. Usual occupation.....

11. Industry or business

12. Name... Daniel Carbaugh
 13. Birthplace... Maryland

14. Maiden name... Susan Fry
 15. Birthplace... Maryland

16. Informant... Frank Carbaugh
 Address... Hagerstown

17. Burial Date thereof... Aug. 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Broadfording Aug 1946
 Location... Washington, Md.
Fred W. Kraiss

18. Funeral director... Fred W. Kraiss
 Address... Hagerstown.

19. Aug. 14 19 46 Margaret B Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 12 19 46 at 5th P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....
 and that I last saw him..... alive on 19.....

Immediate cause of death..... DURATION

chr. alcoholism 10yrs

generalized vascular arterio

sclerosis 5yrs

hypostatic pneumonia 1d

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

DEPUTY MEDICAL EXAM.
WASH. CO., MD.

23. SIGNATURE M. D. [Signature]

Address... Hagerstown, Md. Date signed 8/13/46

MARGIN RESERVED FOR BINDING

VS A15

9.45.15W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 16 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

CERTIFICATE OF DEATH

08368

206

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
532 Salem Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 532 Salem Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dora H. Cash

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife William W. Cash
 8.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 3, 1869
 8. AGE: Years 77 Months 5 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Montebello, Virginia
 (Town, county, and state)
 10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Daniel S. Cash
 13. Birthplace Montebello, Virginia

MOTHER 14. Maiden name Elza Ann Cash
 15. Birthplace Montebello, Virginia

16. Informant William L. Cash
 Address Hagerstown, Maryland

17. Burial Date thereof 8-14-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
C. M. Suter & Sons

18. Funeral director _____
 Address Hagerstown, Maryland

19. Aug 13 19 46 Margaret B. Bowers
 (Date rec'd by registrar) Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 19 46 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 46 to Aug 11 19 46
 and that I last saw him/her alive on Aug 11 19 46

Immediate cause of death Ch. Myocarditis
Apoplexy

DURATION

2 yrs
3 months

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert P. Courser, M.D.

M. D. or other

Address Hagerstown, Md Date signed 8-12-46

RECEIVED

AUG 15 1946

BUREAU V 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date of deceased is shown on 2411 N. Charles St., Baltimore (137-2)

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FILM No. 106 AUG 23 1946

Reg. Dist. No. 302

1. PLACE OF DEATH:
County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No... 1106 Hamilton Boulevard
(If rural, give LOCATION)
No
2.(a) If veteran, name war

3. (a) FULL NAME
Dixie L. Dern

3. (b) Social Security Number
212-24-5-424

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife... Ida Fike
5. (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) October 26, 1869 1879
8. AGE: Years Months Days If less than one day
66 9 13 ... hrs. ... min.

9. Birthplace... Frederick Co., Md.
(Town, county, and state)
10. Usual occupation... Painter

11. Industry or business
12. Name... Abraham Dern
13. Birthplace... Frederick Co., Md
14. Maiden name... Anna Reddick
15. Birthplace... Frederick Co., Md.

16. Informant... Mrs. Dixie L. Dern
Address... 1106 Hamilton Blvd. Hagerstown, Md

17. Burial Date thereof Aug. 11, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory... Blue Ridge Cemetery
Location... Thurmont, Md.

18. Funeral director... M. L. Creager & Son
Address... Thurmont, Md

19. August 12, 1946 Margaret B. Powers
(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 9, 1946 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1946, to Aug 9, 1946, and that I last saw him alive on August 8, 1946.

Immediate cause of death... Chronic cardiovascular renal disease
DURATION 5 mos.

One to...
One to...

Other conditions... None
(Include pregnancy within 3 months of death)

Major findings of operations... No operation
Date of op. ...

Autopsy results... No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
Accident, suicide, or homicide... Date of...
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury... Injured at work?

23. SIGNATURE... R. Beebe
M. D. or other

Address... Hagerstown, Md. Date signed 8/9/46

RECEIVED

AUG 14 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

CERTIFICATE OF DEATH

★ 08370302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 608 Highland Way
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

David Trenton Dorraugh

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower6. (b) Name of husband or wife Mintie E.6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) February 6 18698. AGE: Years Months Days It less than one day
77 6 24 hrs. min.9. Birthplace Leesburg Loudon Co. Va.
(Town, county, and state)10. Usual occupation Engineer Retired11. Industry or business N. & W.R.R.12. Name No Record13. Birthplace No Record14. Maiden name No Record15. Birthplace No Record16. Informant Mrs. Olive Hope ZellerAddress Hagerstown Md.17. Burial Date thereof 9/1/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Aug. 31. 46 Registrar
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1946 at 9 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 1946 to aug 30 1946
and that I last saw him alive on aug 30 1946Immediate cause of death Cardiac dilatation

DURATION

81/29/46Due to myocarditis chshepatis chs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

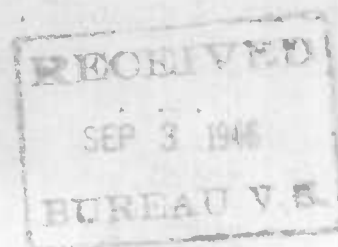
Means of injury Injured at work?

23. SIGNATURE H. L. Porterfield M.D.Address 136 W Washington St M. D. or otherDate signed 8/31/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

08371301
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington County
City or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 yrs
Hospital, institution, or street address where death occurred:
25 E. Potomac St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 25 E. Potomac St.
(If rural, give LOCATION)
None
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. C. Matilda Downs

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Newton K Downs

8.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) July 1 1869

8. AGE: Years 77 Months 1 Days 29 If less than one day
.....hrs.min.

9. Birthplace Williamsport, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Milton Norris

13. Birthplace Williamsport, Md.

14. Maiden name Mary Catherine Bovey

15. Birthplace Maryland

16. Informant Newton K. Downs

Address 25 E. Potomac St. Williamsport

17. Burial Date thereof Sept. 1 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverview Cemetery

Location Williamsport, Maryland

18. Funeral director Edith V. Leaf

Address Williamsport, Maryland

19. Sept 1 19 46 Mrs E Lee McEoy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August. 29 19 46 at 11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 46 to Aug 29 19 46
and that I last saw him alive on Aug. 29 19 46

Immediate cause of death

DURATION

Myocarditis Chronic 6 years

Due to

Due to unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. K. K. K. M. D. or other

Address Williamsport Md Date signed 8/30/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 4 1946

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore 32

08372

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

FILM No. I O 7 OCT 15 1946

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Life
How long in above place of death?
Hospital, institution, or street address where death occurred:
128 East Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 128 East Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Caroline M. Everly

3. (b) Social Security Number

No

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Widow of Richard Everly

7. Birth date of deceased (mo., day, yr.) August 20, 1869 6.(c) If alive, give age years

8. AGE: Years 76 Months 11 Days 26 It less than one day
..... hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Home work

11. Industry or business

12. Name John Lizer13. Birthplace Maryland14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Helen Mc CarneyAddress Hagerstown, 631 N. Locust St

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug 19 1946
(month) (day) (year)

Cemetery or crematory Rose HillLocation Hagerstown18. Funeral director Fred W. Kraiss.Address Hagerstown, Md.

19. Aug. 19 46 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 46 at 4th A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 15-46 to Aug 15-46and that I last saw him on Aug 15-46 19

Immediate cause of death

Chr. Myocarditis

DUE TO

Choleliths

DUE TO

Choleliths

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas H Bowers M. D. or otherAddress Hagerstown Md Date signed Aug 19 46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 21 1946
BUREAU VS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08373302
Reg. Dist. No.

1. PLACE OF DEATH:
County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
W. Washington St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Penna. County... Franklin
City or town... Chambersburg, Penna.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 169 East Queen, St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Wesley Eyer
3. (b) Social Security Number 190-01-5397

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Marion Jaretta Eyer

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1890
6. (c) If alive, give age _____ years

8. AGE:
Years 56 Months 6 Days 20
If less than one day _____ hrs. _____ min.

9. Birthplace Chambersburg, Penna.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name J. Wesley Eyer

13. Birthplace Chambersburg, Penna.

14. Maiden name Anna Peiffer

15. Birthplace Chambersburg, Penna.

16. Informant Marion Eyer

Address Chambersburg, Penna.

17. Burial Date thereof Aug. 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lincoln Cemetery

Location Chambersburg, Penna.

18. Funeral director Paul Kraiss

Address Chambersburg, Penna.

19. Aug 28 1946 Chas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH August 27, 1946 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27-46 to Aug 27-46
and that I last saw him dead on Aug 27-46 19____

Immediate cause of death (Accident)

Due to Fracture skull

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8/27/46

Where did injury occur? Chambersburg
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at place of employment

Means of injury Self Injured at work? yes

23. SIGNATURE Dr. E. W. Lutz
Address Hagerstown Md Date signed 8/27/46
M.D. or other Chas H. Bowers

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 30 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... WashingtonCity or town... Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sophia Daisy Faith

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Charles Faith6. (c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) April 1 18738. AGE: Years 73 Months 4 Days 11 If less than one day
..... hrs. min.9. Birthplace Martinsburg, W. Va.
(Town, county, and state)10. Usual occupation Home Work

11. Industry or business

12. Name Denton Gehr13. Birthplace Martinsburg, W Va,14. Maiden name Not Known15. Birthplace Not Known16. Informant Charles FaithAddress Hancock, Md.17. Burial Date thereof Aug. 14 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Green WayLocation Berkeley Spring, W Va.18. Funeral director Snyder-RowlandAddress Hancock, Md.19. Aug-14-46 19 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 46 at 1:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 1 19 45 to Aug 12 19 46
and that I last saw him alive on July 29 19 46

Immediate cause of death

Malignancy-colon-

Duration

3Distant Myocarditis withpericardial adhesions

Duration

2

Due to

None

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Archie Robert CohenAddress Berkeley Spring Md. M. D. 8-14-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 17 1946
BUREAU V. &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 822

CERTIFICATE OF DEATH

0837302
Reg. Dist. No.

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49-1-47
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pangborn Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war World War No. 1

3. (a) FULL NAME
R. Frank Garvin

3. (b) Social Security Number
220-05-6733

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Garvin

7. Birth date of deceased (mo., day, yr.) July 3 1997 8. (c) If alive, give age 50 years

8. AGE: Years 49 Months 1 Days 7 If less than one day
hrs. min.

9. Birthplace Hagerstown Wash. Md.
(Town, county, and state)

10. Usual occupation Paper Hanger

11. Industry or business Self

12. Name William H. Garvin

13. Birthplace Franklin County Pa.

14. Maiden name Laura Moore

15. Birthplace Green Spring Furnace Wash. Md.

16. Informant Mrs. Mary Garvin

Address Hagerstown Md.

17. Burial August 12, 1946
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rose Hill, Cemetery

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. August 12 1946 Margaret B. Bourne
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION EDT
20. DATE OF DEATH August 10 1946 at 12:55 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw him alive on Aug/10/46 19

Immediate cause of death acute cerebral hemorrhage DURATION 20hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE S. Robert & Wells M.D. M. D. or

Address Hagerstown, Md. Date signed 8/12/46

MARGIN RESERVED FOR BINDING

I

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 14 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (250)

CERTIFICATE OF DEATH

Reg. Dist. No. 08376 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 9 Weeks
 Hospital, institution, or street address where death occurred:
Washington Co. Hospital
 How long in hospital or institution?..... 9 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Penna. County..... Franklin
 City or town..... Greencastle
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.R.3
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

MARGIE GRACE GOSSARD

3. (b) Social Security Number

4. Sex..... F
 5. Color or race..... W
 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... David Gossard
 6.(c) If alive, give age..... 65 years
 7. Birth date of deceased (mo., day, yr.)..... October 2, 1893
 8. AGE: Years..... 52 Months..... 10 Days..... 0
 If less than one day..... hrs. min.

9. Birthplace..... Leitersburg, Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....
 12. Name..... Daniel Baker
 13. Birthplace..... Leitersburg, Md.
 14. Maiden name..... Fannie Miner
 15. Birthplace..... Leitersburg, Md.

16. Informant..... David Gossard
 Address..... Greencastle R.R.3
 17. Burial..... Date thereof..... Aug. 4, 1946
 (Burial, cremation, or removal. Which?).....
 Cemetery or crematory..... Broadfording
 Location..... Near Cearfoss
 18. Funeral director..... Jack A. Smith
 Address..... Greencastle, Penna.
 19. Aug. 4, 1946 W. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 8/2 1946 at 1:45 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
8/1 1946 to 8/2 1946
 and that I last saw her alive on 8/1 1946
 Immediate cause of death..... Disseminated
Miliary Tuberculosis
 DURATION..... 6 months

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results..... Miliary tuberculosis
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... W. H. Bowers
 Address..... Greencastle, Pa. Date signed..... 8/3/46
 M. D. or other.....

MARGIN RESERVED FOR BINDING

VS A15 9.45.1E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 6 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 26 W. C. Church Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME Harold Leonard Grant

3. (b) Social Security Number _____

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Lucy Grant
 6. (c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) January 29, 1876
 8. AGE: Years 70 Months 6 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Spielmanns Station Md
 (Town, county, and state)
 10. Usual occupation Laborer

11. Industry or business _____
 12. Name Mose Grant
 13. Birthplace Spielmanns Station Md
 14. Maiden name Nancy Curren
 15. Birthplace Spielmanns Station Md

16. Informant Mrs. Lucy Grant
 Address 26 W. C. Church St.

17. Burial Date thereof 8/13/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director William H. Downey
 Address 2414 Fredrick St Hagerstown

19. Aug. 13 19 46 Margaret B. Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 46 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 46 19 to Aug 10 19 and that I last saw him alive on Aug 10 19.

Immediate cause of death myocardial infarction
known myocardial

Due to hypertension

Due to hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. B. B. B. M. D. _____

Address Hagerstown Date signed Aug 11 46

REC'D

AUG 15 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08378

Reg. Diat. No. 302

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 years
 Hospital, institution, or street address where death occurred: Washington County Hospital
 How long in hospital or institution? 3 days

3. (a) FULL NAME

Julius Grass

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: 43 Years Months Days If less than one day _____ hrs. _____ min.

9. Birthplace Burkittsville, Md.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business _____

MOTHER FATHER 12. Name C. Larence Grass

13. Birthplace Burkittsville, Md.

14. Maiden name Betta Jones

15. Birthplace Burkittsville, Md.

16. Informant Leannara Grass

Address Church Street

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 8 / 18 / 46

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director William A. Downey

Address 291 Frederick St.

19. Aug. 19, 46 Registrar Blair Bowers

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1800 same Court
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

214-096467

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 1946 at 12:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Aug 46 to 15 Aug 46
 and that I last saw him alive on 14 Aug 46

Immediate cause of death _____

Cerebral hemorrhage

sub. arach. mal. meningeal

Due to hypertension

vascular renal disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. D. Layman, M.D.

Address 100 Professional Bldg Date signed 16 Aug 46

Hagerstown, Md.

RECEIVED

AUG 20 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Yeager

231

08379

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:
222 South Potomac St.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 222 So. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Iowa A. Hahn

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 8.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Isaac L.

6.(c) If alive, give age -- years
 T. Birth date of deceased (mo., day, yr.) September 23 1860

8. AGE: Years 85 Months 11 Days 8 If less than one day hrs. min.

9. Birthplace Sabillasville, Frederick Co., Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Adam Eyler
 13. Birthplace Sabillasville Md.

MOTHER 14. Maiden name Margaret McClain
 15. Birthplace Sabillasville Md.

16. Informant Miss Dora G. Hahn
 Address Hagerstown Md

17. Burial Date thereof 9/3/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Aug. 31, 1946 Registrar Charles Bowers
 (Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1946 at 12.10 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 to Aug. 31 1946
 and that I last saw him alive on Aug. 28 1946

Immediate cause of death Intermination DURATION 10 yr

Due to myocardial infarction
acute Deventer

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations No Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of

Where did injury occur? X (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Howard Yeager M. D. or other
 Address Hagerstown, Md Date signed Aug. 31, 46

RECEIVED

SEP 3 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
430 East Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 430 East Washington Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Paul B. Harbaugh

3. (b) Social Security Number

214-09-3376

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lena Harbaugh
 6. (c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) March 14, 1887
 8. AGE: Years 59 Months 4 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Sabillasville, Maryland
 (Town, county, and state)
 10. Usual occupation Silk Weaver
 11. Industry or business Federal Silk Mill
 12. Name John M. Harbaugh
 13. Birthplace Sabillasville, Maryland
 14. Maiden name Mary C. Harbaugh
 15. Birthplace Sabillasville, Maryland

16. Informant Mrs. Paul Harbaugh
 Address Hagerstown, Maryland
 17. Burial Date thereof 8-12-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. August 12 19 46 Margaret B. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug. 10, 1946 at 7:45 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17, 1925 to Aug. 10, 1946
 and that I last saw him alive on Aug. 9, 1946
 Immediate cause of death Cerebral Thrombosis
Spt. Hemiplegia
 Due to hypertension
arteriosclerosis
 Other conditions _____

DURATION

4 days
4.2 daysFeb. 19-28
Feb. 19-28

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Howard Yeager M. D. or other _____
 Address Hagerstown, Md Date signed Aug. 10, 1946

RECEIVED

AUG 14 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

Dr. Wells

196

08381

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Washington Co. Hospital
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 111 East Baltimore Street
 (If rural, give LOCATION)
 No. No.
 2.(a) If veteran, name war No.

3. (a) FULL NAME

Jesse Lee Harr

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Cora E.
 6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 9, 1880
 8. AGE: Years 66 Months 1 Days 28 It less than one day hrs. min.

9. Birthplace Clearspring Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Inspector Retired

11. Industry or business Western Md. Rail Road

12. Name David Harr

13. Birthplace Clearspring, Maryland

14. Maiden name Lucy Myers

15. Birthplace Clearspring, Maryland

16. Informant Mrs. Cora E. Harr

Address Hagerstown, Maryland

17. Burial Date thereof Aug. 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Little Rose Hill Cem.

Location Near Clearspring, Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Maryland.

19. Aug. 8, 46 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1946 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14, 1946 to Aug 7, 1946
 and that I last saw him alive on Aug 7, 1946

Immediate cause of death Chr. myocarditis DURATION 3yrs

Due to coronary arteriosclerosis 5yrs

Benign prostatic hypertrophy 14yrs

Due to acute ventricular fibrillation

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Robert Wells, M.D. M. D. or other

Address Hagerstown, Md. Date signed 8/8/46

RECEIVED
AUG 10 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

Dr. Ditto

227

08382

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 Years
 Hospital, institution, or street address where death occurred:
1111 Virginia Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1111 Virginia Ave
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war None

3. (a) FULL NAME

Charles Haller Hess

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) February 11 1882
 6. (c) If alive, give age - years

8. AGE: Years 64 Months 6 Days 16 If less than one day
hrs. min.

9. Birthplace Quicksburg Shenandoah Co. Va.
 (Town, county, and state)

10. Usual occupation Shoe Repair Man11. Industry or business --12. Name John B. Hess13. Birthplace Gettysburg Pa.14. Maiden name Mary Lowry15. Birthplace Gettysburg Pa.16. Informant Mrs. Charles E. JonesAddress Hagerstown Md.

17. Burial Date thereof 8/30/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Aug 30 1946 Charles Hess
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 27 1946 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 46 to Aug 27 46
 and that I last saw him alive on Aug 27 46 1946

Immediate cause of death Circumferential stroke

DURATION

6 minDue to ---Due to ---Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE Dr. Ditto M. D. or otherAddress Hagerstown Md. Date signed ---

RECEIVED

SEP 2 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 08383 306

1. PLACE OF DEATH:

County... WashingtonCity or town... Smithsburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... WashingtonCity or town... Smithsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Walter O. Hines

3. (b) Social Security Number

216-14-6308

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

M.

6. (b) Name of husband or wife

Corra Jerey Hines

7. Birth date of

deceased (mo., day, yr.)

May 12, 18826. (c) If alive, give age 45 years

8. AGE:

Years

Months

Days

If less than one day

64316

hrs.

min.

9. Birthplace

Howville Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Daniel O. Hines

13. Birthplace

Fred. Co., Md.

MOTHER

14. Maiden name

Virginia Brown

15. Birthplace

Fred. Co., Md.

16. Informant

Mrs. Corra Hines

Address

Smithsburg Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 31, 1946
(month) (day) (year)

Cemetery or crematory

Smithsburg Cemetery

Location

" Md.

18. Funeral director

Walter J. Grove

Address

Waynesboro Pa.

19.

(Date rec'd by registrar)

19 4619 46Geo H Torgue
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 19 46 at 5:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 29 19 46 to Aug 25 19 46and that I last saw him alive on Aug 28 19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

24 hrs

Due to

arterio-sclerosis7 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. G. H. Ocker

M. D. or other

Address Smithsburg Date signed 8/29/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

SEP 6 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Dr. Kneisley

250

08384

Reg. Diat. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 Years

Hospital, institution, or street address where death occurred:

336 North Cannon AveHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 336 North Cannon Ave
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Frederick Thomas Hose

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteWidower6. (b) Name of husband or wife Leatha E.6. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) January 4 18728. AGE: Years Months Days If less than one day
74 7 4 hrs. min.9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)10. Usual occupation Mechanic Retired11. Industry or business Automobile12. Name John Hose13. Birthplace Hagerstown Md.14. Maiden name Mary Burkhart15. Birthplace Hagerstown Md.16. Informant Mrs. Harry HahnAddress Hagerstown Md.17. Burial Date thereof 8/10/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Aug. 9 46 Cliff Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 19 46 at 1 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 26, 1946 19 46 to August 8, 1946 19 46
and that I last saw him alive on August 7, 1946 19 46Immediate cause of death Coronary occlusion

DURATION

10 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D.

M. D. or other

Address 148 W. Washington St. Date signed 8/9/46

RECEIVED
AUG 10 1945
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Dr. Victor Miller

08385

Reg. Dist. No. 303

1. PLACE OF DEATH:

County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, institution, or street address where death occurred:
316 South Prospect Street
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 316 South Prospect St.
(If rural, give LOCATION)
None
2.(a) If veteran, name war

3. (a) FULL NAME

George Shafer Jones

3. (b) Social Security Number

214-09-4916

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife... Mary M.
6. (c) If alive, give age... 55 years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1888

8. AGE: Years Months Days If less than one day
57 7 11 hrs. min.

9. Birthplace... Stellton, Dauphin Co., Penna.
(Town, county, and state)

10. Usual occupation... Painter

11. Industry or business... Automobile

12. Name... John W. Jones

13. Birthplace... Magnolia Maryland

14. Maiden name... Adaline Pummell

15. Birthplace... Magnolia, Maryland

16. Informant... Mrs. Mary M. Jones

Address... Hagerstown, Md.

17. Burial Date thereof... 8/8/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rose Hill Cemetery

Location... Hagerstown, Maryland.

18. Funeral director... Andrew K. Coffman

Address... Hagerstown, Maryland.

19. Aug. 6. 46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 6, 1946, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 6, 1946 to Aug. 6, 1946 and that I last saw him alive on Aug. 6, 1946.

Immediate cause of death

Cancer, carcinoma 3 hrs.

Due to Antecedent

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D.

Hagerstown Date signed 8.6.46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 10 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

08386

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
129 West Washington Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 129 West Washington Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Clarence Keedy

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 17, 1878

8. AGE:

Years

68

Months

3

Days

2

If less than one day

.....hrs.min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)10. Usual occupation Insurance Broker11. Industry or business Clarence Keedy & Co.12. Name Henry H. Keedy13. Birthplace Hagerstown, Maryland14. Maiden name Julia Lane15. Birthplace Hagerstown, Maryland16. Informant Mrs. H. H. Keedy, Jr.Address Hagerstown, Maryland17. Burial Date thereof 8-21-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. Aug 19 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19-46 19..... at 11:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-19-46 19..... to 8-19-46 19.....and that I last saw him alive on 8-19-46 19.....

Immediate cause of death

DURATION

Cerebral ThrombosisDue to long term illness

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. W. Ditt M. D.Address Hagerstown, Md. Date signed Aug 19 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 21 1945
BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 08387 300

1. PLACE OF DEATH

County Wash. #4 Washington Co.
City or town near Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 wks. in the
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town near Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wash. #4
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Ellen Keeney

3. (b) Social Security Number

4. Sex Female 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife James L. Keeney
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Jan 5 1856
8. AGE: Years 90 Months 7 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick County
(Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business

12. Name Stephen Bridinger
13. Birthplace Frederick County
14. Maiden name Mary Ann Bridinger
15. Birthplace Frederick County

16. Informant James L. Keeney
Address Sharpsburg

17. Burial Date thereof Aug 20 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Hill
Location near Woodbury Rd

18. Funeral Director G. C. Barton
Address Halpersville, Md.

19. Aug 20 1946 Registrar E. J. Boyce
(Date signed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946 at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1946 to Aug 17 1946
and that I last saw him alive on Aug 17 1946
Immediate cause of death Cerebral
Disorder of
Cardio Vascular System 2 yrs.

DURATION
24 hrs.

Due to None
Other conditions None

Due to None
Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? None
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of Injury Injured at work?

23. SIGNATURE Ralph F. Gump M. D. or other
William Spaulding Date signed 8/19/46
Address

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 6 1948

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

08388

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 43 Years
 Hospital, institution, or street address where death occurred:
18 Broadway
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 18 Broadway
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Edith Brown Keller

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife C. Harry
 6.(c) If alive, give age 81 years
 7. Birth date of deceased (mo., day, yr.) March 7 1864
 8. AGE: Years 82 Months 4 Days 24 hrs. - min.

9. Birthplace Spice Creek Huntingdon Co., Pa.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Benj Franklin Brown

13. Birthplace Huntingdon Pa.

14. Maiden name Martha Steward

15. Birthplace Huntingdon Pa.

16. Informant Mr. C. Harry Keller

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 9/2/46
 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Aug. 31, 46 Registrar Charles H. Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 31 1946 at 4 PM

21. I CERTIFY that death occurred on the data above stated: that I attended deceased from Mar 1 1946 to Aug 31 1946
 and that I last saw him/her alive on Aug 31 1946

Immediate cause of death Ch. Myocarditis
& Mitral valve disease

DURATION

6 yrs6 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D. M. D. or other

Address Hagerstown, Md. Date signed 8-31-46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08389 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 941 Forrest Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Samuel Negley Loose

3. (b) Social Security Number

214-09-3460

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife..... Phyllis Loose7. Birth date of deceased (mo., day, yr.) June 11, 1879 6. (c) If alive, give age 56 years8. AGE: Years 67 Months 2 Days 4 It less than one day
..... hrs. min.9. Birthplace..... Hagerstown, Wash. Co. Md.
(Town, county, and state)10. Usual occupation..... Executive11. Industry or business..... Tri-State Electric Co.FATHER 12. Name..... Samuel B. Loose
13. Birthplace..... Hagerstown, MarylandMOTHER 14. Maiden name..... Rose Negley
15. Birthplace..... Hagerstown, Maryland16. Informant..... Mrs. Samuel N. Loose
Address..... Hagerstown, Maryland17. Burial Date thereof..... 8-17-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Rose Hill Cemetery
Location..... Hagerstown, Maryland18. Funeral director..... C. M. Suter & Sons
Address..... Hagerstown, Maryland19. Aug 17 19 46 Chas H Bowers
(Date recd. by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 15, 1946, at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 3, 1946 to Aug 15, 1946
and that I last saw him alive on Aug. 15, 1946Immediate cause of death..... neoplasm of lung DURATION
6 mos.

Due to.....

Due to.....

Other conditions..... Hemorrhagic pleural effusion 5 mos
Arterio-sclerotic heart disease 10 years
(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... R. S. Stauffer, M.D. M. D. or other
Address..... Hagerstown, Md Date signed Aug 16, 1946

RECEIVED
AUG 20 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

08390

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Bonsboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

n. main stHow long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Bonsboro
(If outside city or town limits, write RURAL and give nearest town)Street No. n. main st.
(If rural, give LOCATION)2.(a) If veteran, name war none

3.(a) FULL NAME

Mary E. Lowery

3.(b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married6.(b) Name of husband or wife Frank E. Lowery

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 3 - 19018. AGE: Years 45 Months 4 Days 2 If less than one day _____ hrs. _____ min.9. Birthplace near Mussile Fred. Co. Md.
(town, county, and state)10. Usual occupation Housewife11. Industry or business Our HomeFATHER 12. Name Sherman E. Wolfe
13. Birthplace Bonsboro Wash. Co. Md.MOTHER 14. Maiden name Dolly Summers15. Birthplace Bonsboro Wash. Co. Md.16. Informant Frank E. LoweryAddress Bonsboro Md.17. Burial Date thereof August 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bonsboro CemeteryLocation Bonsboro Md.18. Funeral director Wm. J. Bast & SonsAddress Bonsboro Md.19. Aug. 8 19 46 John H. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 - 1946 at 6:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 4 19 46, to Aug. 5 19 46, and that I last saw him alive on Aug. 4 19 46Immediate cause of death Chronic myocarditis

DURATION

9 hours

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE John H. Bast, M.D.

M. D. or other

Address Bonsboro Md. Date signed 8/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 10 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

★ 08391302
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Rural Harpers Ferry R. F. D. 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Infant Marshall

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) August 27, 1946

8. AGE: Years Months Days If less than one day
3 hrs. min.

9. Birthplace Washington County Hos. Hag. Wash. Md
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business

12. Name Allen Richard Marshall13. Birthplace Sharpsburg, Md.14. Maiden name Anna Pauline Ely15. Birthplace Sharpsburg, Md16. Informant Allen Richard MarshallAddress Sharpsburg, Md.

17. Burial Date thereof Aug. 31, 1946
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Mt. ViewLocation Sharpsburg Md18. Funeral director R. I. EarnshawAddress Keedysville, Md

19. Aug 31 46 W. H. Bowers
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 19 46, at 2:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 27 1946 to Aug 31 1946
 and that I last saw Aug 31 alive on Aug 31 19 46

Immediate cause of death.....

DURATION

Aspiration pneumonia 2 days
Prematurity

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address Sharpsburg, Md Date signed 8/31/46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 3 1946
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

CERTIFICATE OF DEATH

Reg. Dist. No. 08392 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

Railroad Crossing at Lee Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 252 South Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Elmer McLucas

3. (b) Social Security Number

220-10-3506

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Flake I. McLucas55

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 17, 18818. AGE: Years 65 Months 6 Days 14 If less than one day
hrs. min.9. Birthplace Shippensburg, Pa.
(Town, county, and state)10. Usual occupation Night Watchman11. Industry or business Potomac Motor Company12. Name James A. McLucas13. Birthplace Little Cove, Pa.14. Maiden name Margaret Gilbert15. Birthplace Shippensburg, Pa.18. Informant Mrs. Charles McLucasAddress Hagerstown, Maryland17. Burial 9-4-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. 9-3- 46 Chas. H. Bowers,
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31-46 19 75 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 31-46 to Aug 31-46and that I last saw him dead on Aug 31-46 19 75

Immediate cause of death

stroke & hemorrhageboth legs crushedDue to by railroad car

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-31-46Where did injury occur? Hagerstown Washington (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public HighwayMeans of injury Run over by railroad car Injured at work? no23. SIGNATURE J. W. Suter M. D. or otherAddress Hagerstown, Md Date signed 9/4/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

234

RECEIVED

SEP 5 1946

BUREAU V. K.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (528) X

CERTIFICATE OF DEATH

08393

Reg. Dist. No. 302

1. PLACE OF DEATH:
 County..... Washington County
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 60 years
 Hospital, institution, or street address where death occurred:
1108 Potomac Ave.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Maryland Washington
 State..... Washington County.....
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1108 Potomac Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Laura A. Miller

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Clarence E. Miller
 6. (c) If alive, give age 76 years
 7. Birth date of deceased (mo., day, yr.) June 12, 1868
 8. AGE: Years 78 Months 1 Days 22 It less than one day hrs. min.
 9. Birthplace Near Fairview Wash. Md.
 (Town, county, and state)
None
 10. Usual occupation.....
None
 11. Industry or business.....
None
 12. Name Henry Lum
 13. Birthplace Smoketown Md.
 14. Maiden name Sarah E. Hose
 15. Birthplace Unknown

16. Informant Miss Sarah L. Lum
 Address Washington D.C.
 17. Burial Aug. 7, 1946
 (Burial, cremation, or removal, which?) Date thereof.....
 (month) (day) (year)
 Cemetery or crematory Rest Haven
 Location Hagerstown Md.
 18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.
 19. Aug. 6, 46 Chas H. Boward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1946 at 8:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1945 to Aug 4 1946
 and that I last saw him alive on Aug 4 1946
 Immediate cause of death.....

Carcinoma Bladder 1 1/2 yrs
 Due to.....
Anemia 1 yr
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE Ernest F. Powell M. D. or other
 Address Hagerstown, Md. Date signed 8/5/46

RECEIVED

AUG 8 1946

BUREAU V

ARTISTIAN LEONER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31a)

CERTIFICATE OF DEATH

08394

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 29 years
 Hospital, institution, or street address where death occurred:
 229 West Franklyn,
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 845 Chestnut
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Paul R. Miller

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Jan. 12, 1917

8. AGE:

Years

Months

Days

If less than one day

29

7

000

hrs.

min.

9. Birthplace.....

Hagerstown, Md.
(Town, county, and state)

10. Usual occupation.....

U.S. Soldier

11. Industry or business.....

FATHER

12. Name.....

George L. Miller

13. Birthplace.....

Hagerstown,

MOTHER

14. Maiden name.....

Mary Keller

15. Birthplace.....

West Va.

16. Informant.....

George L. Miller

Address.....

Hagerstown, 845 Chestnut, St

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

Aug 15, 1946

(month) (day) (year)

Cemetery or crematory.....

National Cemetery

Location.....

Sharpsburg, Md.

18. Funeral director.....

Fred W. Kraiss.

Address.....

Hagerstown.

19. (Date rec'd by registrar)

Aug. 14 1946

1946

Margaret B. Bowser
Deputy Registrar

MEDICAL CERTIFICATION

10-15

20. DATE OF DEATH..... August 12, 1946, at..... A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

vascular hypertension

?

Due to..... fatty degeneration of liver

arteriosclerotic kidneys

Due to.....

acute alcoholic narcosis

Other conditions.....

(Includes pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

no

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address..... Hagerstown, Md.
 Date signed..... 8/13/46
 DEPUTY MEDICAL EXAMINER
 WASH. CO., MD.
 M. D. *Robert S. Wells*

RECEIVED
AUG 16 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
658 Virginia Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 658 Virginia Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Frank L. Moats

3. (b) Social Security Number

214-09-9883

| | | |
|-----------------------|----------------------------------|--|
| 4. Sex Male | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Married |
|-----------------------|----------------------------------|--|

6. (b) Name of husband or wife Emma C. Moats
 6. (c) If alive, give age 55 years
 7. Birth date of deceased (mo., day, yr.) December 10, 1884
 8. AGE: Years 61 Months 8 Days 11 If less than one day
 hrs. min.

9. Birthplace Tilghmanton, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Sheet metal worker
 11. Industry or business Fairchild Aircraft
 FATHER
 12. Name Henry P. Moats
 13. Birthplace Tilghmanton, Maryland
 MOTHER
 14. Maiden name Susan Davis
 15. Birthplace Tilghmanton, Maryland

16. Informant Mrs. Frank L. Moats
 Address Hagerstown, Maryland

17. Burial Date thereof 8-24-46
 (Burial, cremation, or removal. Which) (month) (day) (year)
 Cemetery or crematory Manor Cemetery
 Location Tilghmanton, Maryland
C. M. Suter & Sons
 18. Funeral director
 Address Hagerstown, Maryland

19. Aug 23 19 46 Chas H Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 19 46 at 7:56 M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 19 46 to August 21 19 46
 and that I last saw him alive on August 21 19 46

Immediate cause of death Carcinoma of left lung
 DURATION 5 mos.
 Due to
 Due to
 Other conditions Arteriosclerosis years

(Include pregnancy within 3 months of death)
 Major findings of operations Carcinoma of left lung
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE RB Howard M.D. or other
Hagerstown Md
 Address Date signed 8/22/46

RECEIVED
AUG 26 1944
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-2)

CERTIFICATE OF DEATH

Dr. Sullivan 88396

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sharpsburg R#1
(If outside city or town limits, write RURAL and give nearest town)Street No. Bakersville
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Gary Lee Palmer

3. (b) Social Security Number

None

| | | |
|-----------------------|----------------------------------|---|
| 4. Sex <u>Male</u> | 5. Color or race <u>White</u> | 6. (a) Single, married, widowed, or divorced <u>Single</u> |
|-----------------------|----------------------------------|---|

6. (b) Name of husband or wife

6. (c) If alive, give age. 46 years7. Birth date of deceased (mo., day, yr.) August 33 1946

| | | | |
|----------------------------|---------------------|------------------|---|
| 8. AGE: Years <u>46</u> | Months <u>00</u> | Days <u>7</u> | If less than one day <u>00</u> hrs. <u>00</u> min. |
|----------------------------|---------------------|------------------|---|

9. Birthplace Bakersville Washington Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

| | |
|--------|---------------------------------------|
| FATHER | 12. Name <u>Franklin A. Cook</u> |
| | 13. Birthplace <u>Bakersville Md.</u> |

| | |
|--------|---|
| MOTHER | 14. Maiden name <u>Anna Bell Palmer</u> |
| | 15. Birthplace <u>Bakersville Md.</u> |

16. Informant John W. Sisler
Address Sharpsburg Md. R #217. Burial Date thereof 8/30/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain View CemeteryLocation Sharpsburg Maryland18. Funeral director Andrew K. CoffmanAddress Hagerstown Maryland19. Aug 30 46 Blair Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 19 46 at 8 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/30 19 46 to 8/30 19 46
and that I last saw him alive on 8/30 19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Birth Injury

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Blair Bowers M.D.

M. D. or other

Address Hagerstown Md. Date signed 8/30/46

RECEIVED
SEP 2 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

08397

207

1. PLACE OF DEATH: Washington
 County: Rural Hagerstown
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, institution, or street address where death occurred:
 Hagerstown Rt. 4
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Washington
 City or town: Rural Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: Route 4
 (If rural, give LOCATION)
 2.(a) If veteran, name was

3. (a) FULL NAME

Bulah I Petrie

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Luther J. Petrie
 6. (c) If alive, give age 43 years
 7. Birth date of deceased (mo., day, yr.) Jan. 29. 1903
 8. AGE: Years 43 Months 6 Days 9 If less than one day hrs. min.

9. Birthplace Hampshire County W.Va.
 (Town, county, and state)
 House Wife
 10. Usual occupation Own Home
 11. Industry or business
 12. Name Robert R. Wolford
 13. Birthplace Hampshire County W.Va.
 14. Maiden name Minnie Carlisle
 15. Birthplace Hampshire County W.Va.

16. Informant Mr. Luther J Petrie
 Address Hagerstown Rt. 4

17. Burial Date thereof August 10-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. Aug. 10 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 46 6:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

Carcinoma Liver

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

S. Robert Wells DEPUTY MEDICAL EX WASH. CO., MD.

23. SIGNATURE M. D.

Hagerstown, Md. Date signed 8/13/46

RECEIVED

AUG 13 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

08398

302

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington Co. Hospital
How long in hospital or institution: 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(c) If veteran, name war ✓

3. (a) FULL NAME

Betty Jane Porter

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. Single, married, widowed, or divorced Single
6.(b) Name of husband or wife _____
7. Birth date of deceased (mo., day, yr.) May 16 - 1920 8.(c) If alive, give age _____ years
8. AGE: Years 26 Months 3 Days 13 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 29. 46 19_____, at 4:00 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 29-46 19_____, and that I last saw him Aug 29-46 19_____.
Immediate cause of death _____

9. Birthplace Ellerslie, Allegany Co. Md.
(Town, county, and state)
10. Usual occupation Postmaster
11. Industry or business Ellerslie Post Office

Crushed Chest
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

MOTHER FATHER
12. Name Harry R. Porter
13. Birthplace Ellerslie, Md.
14. Maiden name Sydia Lowery
15. Birthplace Ellerslie, Md.
16. Informant Clarence Burkett
Address Ellerslie, Md.
17. Burial Date thereof 9 1 46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Porter
Location Hyndman, Pa.
18. Funeral director G. M. Suter & Sons
Address Hagerstown, Md.
19. Aug 29 19 46
(Date rec'd by registrar) Registrar Shack Bowers

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following: 8/29/46
Accident, suicide, or homicide Crushed Chest Date of 8/29/46
Where did injury occur? Ellerslie (City or town) Md (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of Injury Auto accident Injured at work? no
23. SIGNATURE J. D. W. Ditt
Address Hagerstown, Md. Date signed 8/29/46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4054

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

August 31, 1946

MEMORANDUM FOR

THE ATTORNEY GENERAL

FROM: [illegible]

SUBJECT:

[illegible]

ATTENTION: [illegible]

FOR THE RECORD

RECEIVED
AUG 31 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

08399

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
44 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
2015 Virginia Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2015 Virginia Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

E. Catherine Powell

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Edward C. Powell
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 21, 1867
 8. AGE: Years 78 Months 1 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Near Harpers Ferry W. Va.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name George Earl
 13. Birthplace England

MOTHER 14. Maiden name Sarah E. Nicewarner
 15. Birthplace Mathews Co. Va.

16. Informant Mrs. Ellis Potter
 Address Hagerstown Md.

17. Burial Burial Date thereof Aug 10, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Luthern Cemetery
 Location Funkstown Md.

18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. Aug 9 46 Chas H Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 7:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1939 to Aug 8 1946
 and that I last saw him or alive on Aug 6 1946

Immediate cause of death Cerebral Hemorrhage
Hemiplegia R. side
arteriosclerosis
 DURATION Aug 3 1946
" " "
10 yrs +

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. _____

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

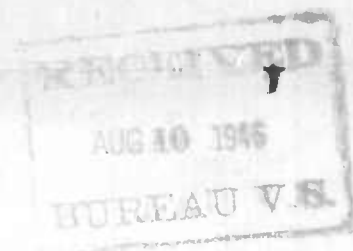
Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE W. Howard Yeager
Hagerstown, Md M. D. or other
 Address _____ Date signed Aug 8, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

08400

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 42 Years
 Hospital, institution, or street address where death occurred:
733 West Church St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 733 West Church Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war No

3. (a) FULL NAME

Mrs Sarah Catherine Renner

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Otho 6. (c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) August 26, 1873
 8. AGE: Years 72 Months 11 Days 23 It less than one day hrs. min.

9. Birthplace Broadfording Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business Own Home
 12. Name Samuel Keyser
 13. Birthplace Broadfording Md.
 14. Maiden name No Record
 15. Birthplace No Record

16. Informant Mrs Bessie Clopper
 Address Hagerstown, Md.
 17. Burial Date thereof Aug. 21, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Broadfording Cemetery
 Location Broadfording, Md.
Andrew K. Coffman
 18. Funeral director
 Address Hagerstown, Md.
 19. Aug 21 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1946 at 1 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17th 1946 to Aug 19th 1946
 and that I last saw alive on Aug 17th 1946
 Immediate cause of death Ch. Myocarditis
 DURATION 5-7 yrs
 Due to Emphysema 10 days
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dr. Ditto M. D. or other
 Address Hagerstown, Md. Date signed 8/19/46

RECEIVED

AUG 23 1946

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (872)

CERTIFICATE OF DEATH

★08401 302
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 40 Years
 Hospital, institution, or street address where death occurred:
 520 Washington Square
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 520 Washington Square
 (If rural, give LOCATION)
 2.(a) if veteran, name war.....

3. (a) FULL NAME

Clarence H. Rubeck

3. (b) Social Security Number

None

4. Sex..... male
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Margaret Rubeck
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... May 8, 1874
 8. AGE: Years Months Days If less than one day
 72 3 5 hrs. min.

9. Birthplace..... Clearspring Dist. Md.
 (Town, county, and state)
 10. Usual occupation..... Retired

11. Industry or business..... Rail Road work

12. Name..... John Rubeck
 13. Birthplace..... Clearspring, Md.

14. Maiden name..... Clarissa Forsythe
 15. Birthplace..... Washington Co. Md.

16. Informant..... Mrs. Rubeck
 Address..... Hagerstown.

17. Burial..... Date thereof..... Aug. 15, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St Paul
 Location..... St. Paul, Hagerstown Rd. 40

18. Funeral director..... Fred W. Kraiss
 Address..... Hagerstown

19. Aug. 14, 1946 Margaret B. Bourne
 (Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

345

20. DATE OF DEATH..... August 13, 1946, at..... A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to..... and that I last saw him..... alive on.....

Immediate cause of death..... Multiple sclerosis..... DURATION..... 8yrs

Due to..... hypostatic pneumonia..... 2 d

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accidental, suicide, or homicide..... no Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?

23. SIGNATURE..... J. R. Wells, M.D., DEPUTY MEDICAL EXAMINER
 Address..... WASH. CO., MD.
 Date signed..... 8/13/46

MARGIN RESERVED FOR BINDING

VS 415

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 16 1946

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 456

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
 City or town Rural Smithsburg #2
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Smithsburg Md. #2
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M.

W.

W.

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 3

1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26

1946

to

Aug 3

1946

and that I last saw him alive on

Aug 1

1946

Immediate cause of death

Myocardial failure
 Intestinal obstruction
 Due to Primary malignancy of cecum
 with marked generalized
 metastasis.

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter L. Wolfinger

J. D. on other

Address

Waynesboro Pa

Date signed 5 Aug 1946

RECEIVED
AUG 24 1946
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 805

1. PLACE OF DEATH:

County Washington
 City or town Mourne - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 1
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Mourne - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mabel Schlosser

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single

7. Birth date of deceased (mo., day, yr.)

January - 12 - 1896

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

50710

hrs.

min.

9. Birthplace

Mourne Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

at home

FATHER

12. Name

E. Thomas Schlosser

13. Birthplace

Mourne Wash. Co. Md.

MOTHER

14. Maiden name

Bessie E. Murray

15. Birthplace

Illinois

16. Informant

Leonard Schlosser

Address

Boonsboro Md. R. 1

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Burial
Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

Chas. J. Bart & Son

Address

Boonsboro Md.

19.

(Date rec'd by registrar)

19

46Aug. 24John H. Beck

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 19 46, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 8 19 46, to Aug. 22 19 46.and that I last saw her alive on Aug. 22 19 46.

Immediate cause of death

Cerebral Hemorrhage

DURATION

14 Days

Due to

Arterial Hypertension1 Year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Robert M. S.

M. D. or other

Address Boonsboro Md. Date signed 8/24/46

RECEIVED
AUG 28 1946
BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08404

1. PLACE OF DEATH

County WashingtonVillage or City HagerstownNo. R. #2Registration Dist. No. 305

St. _____ Ward _____

Length of residence in city or town where death occurred _____ yrs. 1 mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.2. FULL NAME Emma Rebecca SHEFFLER

If U. S. Veteran, specify WAR _____

(a) Residence: No. Rock Forge, Maryland St. _____ Ward _____

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|--|---|
| 3. SEX <u>Female</u> | 4. COLOR OR RACE <u>White</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u> |
| 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Geo. L. Sheffler</u> | | |
| 6. DATE OF BIRTH (month, day, and year) <u>April 8, 1862</u> | | |
| 7. AGE <u>84</u> | Years <u>4</u> | Months <u>1</u> |
| | | Days <u>1</u> |
| | | If LESS than 1 day, _____ hrs. or _____ min. |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u> | |
| | 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. | |
| | 10. Date deceased last worked at this occupation (month and year) | |
| | | 11. Total time (years) spent in this occupation |

12. BIRTHPLACE (city or town) Washington Co. Md
(State or country)13. NAME John Muntz14. BIRTHPLACE (city or town) Germany
(State or country)15. MAIDEN NAME Nancy Polas16. BIRTHPLACE (city or town) Germany
(State or country)17. INFORMANT Mrs. Carrie Honodel
(Address) Hagerstown #5 Md18. BURIAL, CREMATION, OR REMOVAL
Place Green Hill Cemetery Date 8/11, 194619. UNDERTAKER Walter J. Glore
(Address) 271 Church St Hagerstown20. FILED Aug 15, 1946 Ernest De Loach
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

August 9, 1946
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from July 9, 1946 to August 9, 1946I last saw her alive on August 8, 1946; death is said to have occurred on the date stated above, at 7:10 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Tuberculosis pulmonary - chronic -

Date of onset

?

Other Contributory Causes of Importance:

malnutrition
BLIND - TOTAL CAUSE ?

?

Name of operation NONE

Date of _____

What test confirmed diagnosis? CLINICAL Was there an autopsy? NO

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? NO Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify _____

(Signed) Arthur Robert Cohen M. D.(Address) 4 CLEAR SPRING, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

1915

Chronic interstitial nephritis

1921

Cerebral hemorrhage

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

1 week ago

Run over by street car

1 week ago

Peritonitis

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Mr. Henry M. Hochler.
Hagedorn #2
N.D.

OCT 9 1927

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08405

211

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagelstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution Wash. Co. Hosp.
Stay in hospital or inst. (yrs., or mos., or days) 21 days
Stay in this community (yrs., or mos., or days) Y

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Penn. County Franklin
City or town Mercersburg Ward No. R.1
(If outside city or town limits, write RURAL NEAR and give town)
Street No. no (If rural give LOCATION) ✓
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME

Lloyd Smith

3. (b) Social Security Number

now

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Grace Smith
B (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 5, 1879

8. AGE: Years 67 Months 3 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Mercersburg, Pa. R.D.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name John Smith
13. Birthplace Mercersburg, Pa.

14. Maiden name Jane Dwellness
15. Birthplace Mercersburg, Pa.

16. Informant Mrs. Lloyd Smith
Address Mercersburg, Pa. R.1

17. Burial Date thereof 8/16/46
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Farview
Location Mercersburg, Pa.

18. Funeral director F.M. Lininger
Address Mercersburg, Pa.

19. Aug 14 19 46 Margaret B. Bowser
(Date rec'd by registrar) (year) Registrar Defady

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 19 46 at 6:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/24/46 19 46 to 8/13/46 19 46
and that I last saw him alive on Aug. 13, 46 19 46

Immediate cause of death Pulmonary embolism followed
8 days after abdominal
Due to perineal resection for
cancer of rectum

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: Of operations Cancer of rectum

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE R.H. Greenback M. D. or other _____

Address 170 W. Wash. St. Hg. Date signed _____

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

RECEIVED

AUG 16 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH
 County... WASHINGTON
 City or town... R.D. #2 - HAGERSTOWN
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mo. 10 DAYS
 Hospital, institution, or street address where death occurred:
GATEWAY NURSING HOME
 How long in hospital or institution? 1 mo. 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... PENNA. County... FRANKLIN
 City or town... WAYNESBORO
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 234 RINGGOLD STREET
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME
BESSIE ELIZABETH

3. (b) Social Security Number
NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife GRANT U. STITELY

7. Birth date of deceased (mo., day, yr.) JAN. 18, 1870 6. (c) If alive, give age... years

8. AGE: Years 76 Months 6 Days 15 If less than one day... hrs. ... min.

9. Birthplace JOHNSVILLE - FREDRICK, MARYLAND
 (Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business HOME

12. Name FLETCHER RILEY

13. Birthplace MARYLAND

14. Maiden name JEMIMA STRASBURG

15. Birthplace MARYLAND

16. Informant C. HARRY STITELY

Address 20 S. CHURCH ST., WAYNESBORO, PENNA.

17. BURIAL Date thereof AUG. 6, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LIBERTY TOWN CEMETERY

Location LIBERTY TOWN, MARYLAND

18. Funeral director J. Martin Poe

Address 48 S. CHURCH ST., WAYNESBORO, PENNA.

19. Aug. 4, 1946 Registrar Wm. M. Fisher

(Date rec'd by registrar)

MEDICAL CERTIFICATION
 20. DATE OF DEATH Aug 3, 1946 at 11:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1946 to July 9, 1946
 and that I last saw him alive on July 19, 1946
 Immediate cause of death Arteriosclerosis
Heart disease
 Due to Probable malignancy in abdomen
 Other conditions Arteriosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. M. Fisher M. D. or other

Address Waynesboro, Pa Date signed 8/4/46

OCT 9 1946

BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH:

County Washington
City or town Kagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Co. Hospital
How long in hospital or institution? 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Franklin
City or town Chambersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 167 So. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clarence J. Thompson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Eva A. Thompson7. Birth date of deceased (mo., day, yr.) Sept. 17, 1892 6. (c) If alive, give age 52 years8. AGE: Years 53 Months 10 Days 27 If less than one day9. Birthplace Chambersburg, Va.
(Town, county, and state)10. Usual occupation Restaurant Manager

11. Industry or business

12. Name Frank J. Thompson13. Birthplace Franklin Co. Va.14. Maiden name Eva A. Thompson15. Birthplace Franklin Co. Va.16. Informant Mrs. Eva A. ThompsonAddress Chambersburg, Va.17. Removal Removal Date thereof Aug 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory Edgar Grove Cem.Location Chambersburg, Va.18. Funeral director Robert H. HollisAddress Chambersburg, Va.19. Aug 15 19 46 Chas. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1946 at 10:55 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 19 46 to Aug 14 19 46and that I last saw him alive on August 14 19 46Immediate cause of death Hypertensive Cardiovascular disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

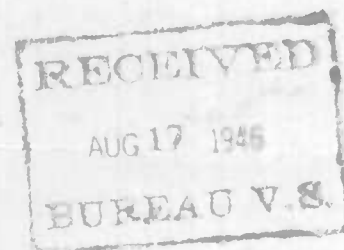
23. SIGNATURE Andrew Hoveston M.D.Address Funk & Son Inc. Date signed 8/15/46

MARGIN RESERVED FOR BINDING

VS A15

9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

08408

Reg. Dist. No. 302

1. PLACE OF DEATH

County Washington
City or town Stagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 wks
Hospital, institution, or street address where death occurred:
Hill Crest Convalescent Home

How long in hospital or institution? 2 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Franklin
City or town Waynesboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. Washington Hotel
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

George Tritle

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 16, 1868

8. AGE:

Years

Months

Days

If less than one day

78

4

15

hrs.

min.

9. Birthplace

Waynesboro Pa.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Daniel Tritle

13. Birthplace

Waynesboro #2, Pa.

MOTHER

14. Maiden name

Elizabeth A. Jacobs

15. Birthplace

Waynesboro #4, Pa.

16. Informant

Address

Richard Smiley
Waynesboro, Pa.

17.

(Burial, cremation, or removal. Which?)

Date thereof

9/4/46
(month) (day) (year)

Cemetery or crematory

Queen Hill

Location

Waynesboro, Pa.

18. Funeral director

Address

Walter J. Gure
321 Church St. Waynesboro, Pa.

19.

(Date rec'd by registrar)

19

Sept. 1, 46
Phas Hoever
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 31

1946

at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 July 1946 to 31 Aug 1946

and that I last saw him alive on 29 Aug 1946

Immediate cause of death

Respiratory paralysis

DURATION

1 hour

Due to

Bulbar paralysis

chronic progressive

7 years

Due to

Anterocervical sclerosis

10 years

Other conditions

generalized laryngeal paralysis

chronic

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

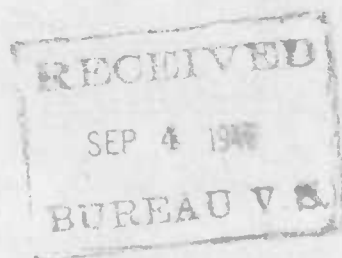
Edouard E. Hanna M.D. or other

Address

Waynesboro Pa

Date signed

1 Sept 46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-17

CERTIFICATE OF DEATH

08409

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 Artisan
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Nancy Jane Turner

3. (b) Social Security Number

4. Sex female 5. Color or race black 6. (a) Single, married, widowed, or divorced single
6. (b) Name of husband or wife none
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Aug 3 1946
8. AGE: Years no Months no Days 1 1/2 If less than one day _____ hrs. _____ min.

9. Birthplace Williamsport Md
(Town, county, and state)
10. Usual occupation none
11. Industry or business none

12. Name Harry Turner
13. Birthplace Williamsport Md
14. Maiden name Mildred Blayden
15. Birthplace Md.
16. Informant Harry Turner
Address 108 Artisan St Williamsport Md
17. burial Date thereof Aug 6th 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill
Location Hagers town Md
18. Funeral director Edith S. Leaf
Address 7 Elmer St Williamsport Md
19. Aug 6 1946 E. Lee McElroy
(Date rec'd by Registrar) Registrar

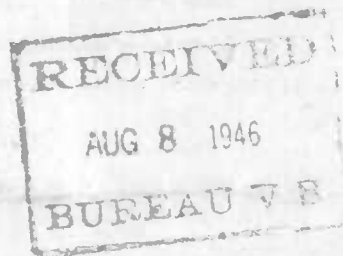
MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 1946
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/3/46 to 8/4/46
and that I last saw him alive on 8/4/46
Immediate cause of death Cardiac Disease
DURATION 1 1/2 days
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations _____
Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
Signature C. F. Young
Address Williamsport Md Date signed 8/4/46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 118410 306

1. PLACE OF DEATH:

County Washington and
 City or town Smithsburg and
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 46 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Smithsburg and
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Jessie Elsworth Warner

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Bertha Irene Warner
 6. (c) If alive, give age 45 years
 7. Birth date of deceased (Mo., Day, Yr.) Aug 6, 1890

8. AGE: Years 46 Months 7 Days 13 It less than one day — hrs. — min.

9. Birthplace Near Smithsburg and
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Laborer

12. Name Jessie Warner

13. Birthplace Near Smithsburg

14. Maiden name Helen J. Gray

15. Birthplace Frederick and

16. Informant Mrs. Mary Kendall

Address Smithsburg and

17. Burial Date thereof Aug 20-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Valley

Location at Pleasant Valley

18. Funeral director Geo. B. Hoover

Address Smithsburg and

19. Aug 19 46 J. B. Ferguson
 (Date read by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17-46 19 — at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 46 to Aug 19 46 and that I last saw him alive on Aug 18 46 19 —

Immediate cause of death (Alcoholism) DURATION

Due to Found dead by father 1 day

Due to apparently dead for at least 2 days

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, publc place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE DW. B. J. acting coroner M. D. or other

Address Hyattsville Md Date signed 9/19/46

RECEIVED
AUG 24 1946
BUREAU V. S.